Hawaii Employer-Union
Health Benefits Trust Fund

IMPORTANT DOCUMENT

This COBRA ADDITIONAL ELECTION NOTICE contains important information and instructions regarding your health benefits continuation coverage under COBRA.

The American Recovery and Reinvestment Act of 2009 (ARRA) provides additional benefits for certain qualified beneficiaries by providing COBRA premium assistance.

You experienced a Job Termination, which is a COBRA qualifying event on or after September 1, 2009 and prior to February 17, 2009. You may qualify for COBRA continuation of coverage for health benefits under ARRA.

Review this document carefully because you may be eligible.

YOUR RESPONSE IS TIME SENSITIVE.

IMPORTANT DOCUMENT

COBRA Continuation Coverage Additional Election Notice

April 15, 2009

This notice contains important information about additional rights to continue your health care coverage in the Hawaii Employer-Union Health Benefits Trust Fund's (EUTF) group health plan(s) (the Plan).

Please read the information contained in this notice very carefully. The pronouns "you" and "your" refer to each of the individuals identified on the Continuation Coverage (COBRA) Election Form (Election Form) included with this notice. This notice provides important information concerning your rights under a federal law known as COBRA which recently was amended by the American Recovery and Reinvestment Act of 2009 (ARRA). It provides instructions regarding what you have to do to continue your health care coverage under the Plan and take advantage of the provisions of ARRA. If you have any questions concerning the information in this notice or your rights to coverage under COBRA, you should contact:

Hawaii Employer-Union Health Benefits Trust Fund
Attn: COBRA Coordinator
P.O. Box 2121
Honolulu, HI 96805-2121
Telephone: (808) 586-7390
Toll Free: (800) 295-0089

The ARRA reduces the COBRA premium in some cases for eligible qualified beneficiaries. You are receiving this notice because you experienced a loss of coverage at some time between September 1, 2008 through February 16, 2009 and either chose not to elect COBRA continuation coverage at that time OR elected COBRA but subsequently discontinued that coverage. If your loss of health coverage was due to an **involuntary termination of employment** you may be eligible for a second COBRA election opportunity and the temporary premium reduction for up to nine months. If you are currently enrolled in COBRA and are eligible for the temporary premium reduction, please refer to the paragraph below. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual." **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed Election Form.**

To elect extended COBRA continuation coverage, you must follow the instructions on the "COBRA Continuation Coverage Election Form" provided and return the completed, signed and dated Election Form to us by mail within the time period described below.

By mail: Hawaii Employer-Union Health Benefits Trust Fund
Attn: COBRA Coordinator
P.O. Box 2121
Honolulu, HI 96805-2121

By hand-delivery: Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1520
Honolulu, HI 96805

Each person ("Qualified Beneficiary") listed for each COBRA option on the form is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan until the date noted on the cover letter. The qualified beneficiaries listed on the form are the only persons eligible to enroll in COBRA.

If elected, COBRA continuation coverage will begin retroactively on March 1, 2009 and can last until up to 18 months after the Qualifying Event Date shown on your Election Form. If you qualify, your COBRA subsidy for 65% of COBRA premiums will continue up through the end of November 2009. If your COBRA period ends beyond that date, your premiums will revert to the standard rate of 102% of the actual premiums.

The cost of COBRA continuation coverage will be based on your plan selections and the type of coverage you desire. You are eligible to enroll only in the plans listed on your Election Form. If you qualify as an "Assistance Eligible Individual" this cost can be reduced to 35% of the cost of the plans that you select for up to nine months. You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you are currently enrolled in COBRA due to an involuntary termination of employment, you may be eligible for premium reduction. **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it to the EUTF.** If your eligibility is validated, your premiums from March 1, 2009 will be revised and reduced to 35% of the premium for each plan in which you are enrolled. The insurance carriers will contact you regarding the overpayment and may either refund you or apply it to future premium payments. You will receive instructions from insurance carriers in which you are enrolled.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact the Hawaii Employer-Union Health Benefits Trust Fund (EUTF):

Attn: COBRA Coordinator
P.O. Box 2121
Honolulu, HI 96805-2121
Telephone: (808) 586-7390
Toll Free: (800) 295-0089

CONTINUATION COVERAGE (COBRA) ELECTION FORM

Fname MI Lname
Address
CitySt Zipcode

EmplID: **HBXXXXXXX**
Notification Date: **MM/DD/YYYY**

First day of COBRA coverage: MM/DD/YYYY
Period of COBRA coverage: 18 months

Qualifying Event: Job Termination
Qualifying Event Date: MM/DD/YYYY

PART A: COBRA Participation

☐ **I am electing COBRA continuation coverage (Complete Part B and sign Part C).**

☐ **I am waiving COBRA continuation coverage (Skip Part B and sign Part C).**

If you want your COBRA information sent to an alternate address, enter your complete alternate address here: _____

PART B: COBRA Plan Elections and Payment Options

I wish to continue coverage(s) indicated below:

YOUR COBRA OPTIONS	**Self Only**	**Two-Party**	**Family**	**Dependents**
Medical				
Medical plan	☐	☐	☐	**Name1** **Name2**
Dental				
Dental plan	☐	☐	☐	**Name1** **Name2**
Vision				
Vision plan	☐	☐	☐	**Name1** **Name2**
Prescription Drugs				
Drug plan	☐	☐	☐	**Name1** **Name2**
Chiropractic				
Chiro plan	☐	☐	☐	**Name1** **Name2**

PART C: Participant Signature

I understand that I must submit my COBRA election to the EUTF no later than the reply deadline. I understand that to qualify for the premium subsidy due to an **INVOLUNTARY TERMINATION OF EMPLOYMENT**, I must submit a completed REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL form to the EUTF. I also understand that my eligibility for the premium subsidy must be validated by my previous employer before I can be enrolled.

SIGNATURE:_____ DATE:_____

NOTE: A parent must sign for a minor if needed

COBRA Continuation Coverage Election Form Instructions

INSTRUCTIONS: To elect COBRA continuation coverage, you MUST complete this Election Form and return the signed and dated form to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan. You may mail, fax or hand-deliver the completed Election Form.

By mail: Hawaii Employer-Union Health Benefits Trust Fund
Attn: COBRA Coordinator
P.O. Box 2121
Honolulu, HI 96805-2121

By hand-delivery: Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1520
Honolulu, HI 96805

By fax: (808) 586-2161

You must complete this Election Form and return it to us within 60 calendar days after the Notification date on the letter. If sent by mail, it must be post-marked no later than 60 calendar days after the Notification Date on the letter. If you fax or deliver the completed form, it must arrive at the EUTF no later than 60 calendar days after the Notification Date on the letter

The following are not acceptable as COBRA elections and will not preserve your COBRA continuation coverage rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's desire to elect COBRA; and electronic or e-mail communications.

IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THE DUE DATE (by the 60th calendar day), YOU WILL LOSE YOUR RIGHT TO ELECT COBRA CONTINUATION COVERAGE. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed Election Form by the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin not on the first day you lost coverage, but (after we receive your first COBRA premium payment) on the date you furnish the completed Election Form.

Specific Instructions about your notice

1. **Notification Date: The notification date is the reference date to which you need to be aware. Your COBRA election form is due to EUTF no later than 60 calendar days after this date.**
2. **First Day of Coverage: Your first day of coverage is the day after you were terminated from the EUTF group health plan. This day is determined by the COBRA law and cannot be changed except as noted above.**
3. **Your last day of coverage can be moved up if specific events occur. Please read the attached information for specific information.**
4. **On the election form itself:**

<u>Header</u>

   a. **Qualifying Event: This is the COBRA qualifying event that, by Federal law, requires your employer to provide continued health benefits coverage at your expense.**
   b. **Date of Qualifying Event: Your continuation of coverage begins beyond this date. If your dependents were covered under the Plan on the last day of active coverage, their benefits can also continue.**

<u>Part A: COBRA participation</u>

   a. **If you decide to waive your right to COBRA, check the appropriate box, sign the form and submit it to the Plan.**
   b. **If any of your qualified dependents chooses to enroll individually, make a copy of the blank form for each family member choosing to enroll separately. You may still enroll the rest of the family under your enrollment.**
   c. **If a family member lives separately (in school), please provide an address to ensure that the proper documents are sent to the correct member.**

<u>Part B:</u> The plans and qualified beneficiaries listed are those that were active on the last day of coverage. You may only enroll in those plans that you had been enrolled on the last day of coverage.

<u>Part C:</u> Please complete this form by signing the form. Failure to submit a complete, signed form may cause you to become ineligible for COBRA benefits.

Read the "Important Information About Your COBRA Continuation Coverage Rights" for more specific explanation regarding your COBRA rights and responsibilities.

Important Information About Your COBRA Continuation Coverage Rights

Am I eligible to elect COBRA continuation Coverage at this time?

Only individuals who lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period, and who did not elect COBRA continuation coverage during their first election period OR who elected but subsequently discontinued COBRA coverage (for reasons other than becoming eligible for another group health plan or Medicare), are entitled to elect coverage at this time. If you lost group health coverage for any other reason between these dates and did not elect COBRA continuation coverage when it was first offered, you are not entitled to this second election period.

Am I eligible for the premium reduction?

If you lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period and are not eligible for Medicare or other group health plan coverage, you are entitled to receive the premium reduction. Information about the amount of the premium reduction and how it affects your premium payments can be found below under the question, "How much does COBRA continuation coverage cost?"

How long will continuation coverage last?

Your coverage will begin retroactively on March 1, 2009 and can generally continue for up to 18 months from the date of your involuntary termination of employment. The duration of the premium reduction is determined separately and may not last for the entire length of your COBRA coverage. See the question below entitled *"How much does COBRA continuation coverage cost?"*

Continuation coverage will be terminated before the end of the 18 month period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- The employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage for participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the EUTF of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

You must provide the EUTF with notice of the Social Security Administration's disability determination within 60 days after the latest of

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction in hours of employment; or
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the covered employee's termination of employment or reduction in hours of employment.

In addition, in order to be entitled to the disability extension you must provide the EUTF with notice of the Social Security Administration's disability determination within 18 months after the covered employee's termination of employment or reduction in hours of employment. If you provide notice to the EUTF of the Social Security Administration's disability determination at a date more than 18 months after the covered employee's termination of employment or reduction in hours of employment, you will not be entitled to the disability extension, even if you provided the notice within 60 days after receiving the Social Security Administration's disability determination.

You must provide notice of the disability determination in writing by appropriately completing the attached "Notice of a COBRA-Related Event." You must follow the procedures specified below in the section entitled "Notice Procedures" and you must return the signed and dated form along with appropriate supporting documentation of the Social Security Administration's disability determination within the time period described above. The section entitled "Notice Procedures" also describes what the Plan will accept as appropriate supporting documentation of the initial Qualifying Event. Oral notice, including notice by telephone, is not acceptable, and electronic notice by e-mail is not acceptable. You may return the "Notice of a COBRA-Related Event" to the EUTF by mail, by fax or by hand-delivery according to the procedures specified below in the section entitled "Notice Procedures." If you do not follow these procedures or if you fail to provide written notice to the EUTF within the 60-day notice period described above, **THEN YOU AND ANY OTHER FAMILY MEMBERS WHO ARE QUALIFIED BENEFICIARIES WILL NOT BE ENTITLED TO THE DISABILITY EXTENSION OF YOUR COBRA CONTINUATION COVERAGE.**

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's

becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

For second Qualifying Events (death of the employee, divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must provide the EUTF with written notice of the second Qualifying Event within 60 days after the second Qualifying Event occurs.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. If you do elect continuation coverage under this additional election period, the period from qualifying event to the date coverage begins under your election will not count as a break in coverage in determining whether you had a 63-day break in coverage.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. The insurance carriers will provide you with a payment notice. You must make your first payment for continuation coverage not later than 45 days after the date of payment notification from the insurance carrier. If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your payment notice, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the appropriate insurance carrier to confirm the correct amount of your first payment.

First payment for COBRA continuation coverage

If you elect COBRA continuation coverage, DO NOT send any payment with the Election Form. You will be billed by the insurance carrier. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. This is the date the Election Notice is post-marked when you mail it back to us, the date embedded in the fax transmittal if you fax the Election Notice back to us, or the date stamped on the Election Notice if you hand-deliver the notice to us. **If you do not make your first payment for COBRA continuation coverage in full within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.**

Your first payment must cover the cost of COBRA continuation coverage first day after your coverage under the Plan terminated up through the end of the month before the month in which you make your first premium payment. You are responsible for making sure that the amount of your first payment is correct. If you are not sure about the amount of your first COBRA premium payment, you may access the COBRA rates at the EUTF website. Otherwise, you can contact the COBRA Coordinator at the Hawaii Employer-Union Health Benefits Trust to confirm the correct amount of your first payment.

Grace periods for periodic payments

Although periodic payments are due on the first day of the coverage month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan may be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first COBRA premium payment should be sent to the appropriate insurance company at the address shown in the attachment or as instructed by the insurance company.

For more information

This notice does not fully describe COBRA continuation coverage or other rights under the Plan. More information about COBRA continuation coverage and your rights under the Plan is available in the appropriate Reference Guide and in the "COBRA Notice" both of which are available on-line at the EUTF's website at: www.eutf.hawaii.gov or from the EUTF.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of the appropriate Reference Guide, you should contact the EUTF at:

Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121
Telephone: (808) 586-7390
Toll Free: (800) 295-0089

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa. State and local government employees should contact HHS-CMS at NewCobraRights@cms.hhs.gov or www.cms.hhs.gov/COBRAContinuationofCov/.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the EUTF informed of any changes in your address and the addresses of family members. Submit any address changes using the attached Change of Address Form to the EUTF. You should also keep a copy, for your records, of any notices and forms you send to the EUTF.

Hawaii Employer-Union Health Benefits Trust Fund	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	P.O. Box 2121 Honolulu Hawaii 96805

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the next page)	Telephone Number E-mail address (optional)

TO QUALIFY, YOU MUST BE ABLE TO CHECK "YES" FOR ALL STATEMENTS.*

1. The loss of employment was involuntary	☐ Yes	☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	☐ Yes	☐ No
3. I elected (or am electing) COBRA continuation coverage.*	☐ Yes	☐ No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium.)	☐ Yes	☐ No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium.)	☐ Yes	☐ No

***If you checked NO for Statement 3, you may still be eligible. See below for more information**

If your COBRA continuation coverage relates to an involuntary loss of employment prior to or on December 31, 2009, and you were eligible for, but waived COBRA coverage, you still have the right to to revoke your waiver and elect to enroll in COBRA. You must, however, revoke and submit your waiver in writing within the 60-day election period. In this scenario, your COBRA start date may begin on the date your waiver is revoked and therefore, your premium subsidy will not begin until that date. You can contact the EUTF at 586-7390 or toll free at 808-295-0089 or at 201 Merchant Street, Suite 1520, Honolulu Hawaii 96813 or go to our website at www.eutf.hawaii.gov for more information.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature _____ Date_____

Type or print name:_____ Relationship to Employee:

FOR EMPLOYER VALIDATION

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary	☐
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	☐
3. Individual was not enrolled in a health benefit plan when terminated.	☐

4. Other (please explain)

Signature of employer:

Signature _____ Date_____

Type or print name:_____	Position Title_____
Telephone Number:_____	E-mail address:_____

To apply for ARRA Premium Reduction, complete this form and return it to the EUTF along with you COBRA Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual to the EUTF at P.O. Box 2121, Honolulu HI 96805 or you can deliver it to our office at 201 Merchant Street, Suite 1520, Honolulu Hawaii 96813.

Be sure to read the important information about your rights and responsibilities included in the "Summary of the COBRA Premium Reduction Provisions under ARRA." For more detailed information, please access our website at www.eutf.hawaii.gov.

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL (continued)

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name	Date of Birth	Relationship	SSN
a.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
b.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
c.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
d.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
e.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

NOTE: If there are more dependents, please make a copy of this page and complete it for your additional dependents.

Hawaii Employer-Union Health Benefits Trust Fund	**NOTIFICATION OF INELIGIBILITY FOR COBRA PREMIUM ASSISTANCE**	P.O. Box 2121 Honolulu Hawaii 96805

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the next page)	Telephone Number
	E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION - Check one

I am eligible for coverage under another group health plan. If any dependents are also eligible, include their names below.	Enter the date you became eligible:

Enter the group health plan name: _____

If you are eligible for coverage under another group health plan and that plan covers dependents, you must also list their names here.

	_____		_____
	_____		_____
	_____		_____
	_____		_____

I am eligible for Medicare.	Enter the date you became eligible:

IMPORTANT

The American Recovery and Reinvestment Act of 2009 limits the period of premium assistance available to involuntarily terminated employees.

1 Up to nine months maximum

2 When you become eligible to enroll in another group heal plan

3 When you become eligible for Medicare benefits

4 For high income individuals, premium assistance is not available

If you have a modified adjusted income exceeding $125,000

If you file a joint return, a modified adjusted income exceeding $250,000

Failure to report your ineligibility timely may result in excess reimbursements. Any ineligible payments can be treated as an underpayment of your payroll taxes and may be assessed and collected in the same manner as payroll taxes in accordance with Subchapter B of Chapter 65 of the Internal Revenue Code of 1986, SEC. 6432. COBRA PREMIUM ASSISTANCE.

If you fail to notify the EUTF when you become eligible forother group health plan coverage or Medicare AND continue to pay reduced COBRA premiums, you could be subject to a fine of 110% of the amount of the premium reduction (Subchapter B of Chapter 65 of the Internal Revenue Code of 1986, SEC. 6720C.)

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature:_____ Date:_____

Type or print your name:_____

CHANGE OF ADDRESS FORM

Attn: COBRA Coordinator
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121

The undersigned is hereby providing notice to the COBRA Coordinator of the EUTF's group health plan(s) of a change in the mailing address of an employee, Qualified Beneficiary or other Plan Participant. The individuals identified below reside at the addresses shown below as of the date of this Form.

_____	_____
Name	*Name*
_____	_____
Mailing address	*Mailing address*
_____	_____
City, State, Zip code	*City, State, Zip code*
_____	_____
Relationship to Employee	*Relationship to Employee*
_____	_____
Name	*Name*
_____	_____
Mailing address	*Mailing address*
_____	_____
City, State, Zip code	*City, State, Zip code*
_____	_____
Relationship to Employee	*Relationship to Employee*
_____	_____
Signature of Employee	Date
_____	_____
Name of Employee	Social Security Number of Employee